Washington State
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

Medical Assistance Administration

Indian Health Services, Tribal 638, and Tribal Mental Health Services

Billing Instructions

October 2003

About this publication

This publication supersedes all previous MAA Indian Health Services Billing Instructions.

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Important Contacts

Where do I call for information on becoming a DSHS provider; submit a provider change of address or ownership; or to ask questions about the status of a provider application?

Call the toll-free line:
(866) 545-0544

Where do I send my claim?

Division of Program Support
PO Box 9248
Olympia WA 98507-9248

Where do I call if I have questions on…?

Mental Health?

Mental Health Division
(360) 902-0787 or
(360) 902-0845

Indian Health – Medical or Dental?

Indian Health Program Manager
Medical Assistance Administration
(360) 725-1649

Where do I call if I have questions on…?

Payments, denials, general processing questions?

Provider Relations Unit
1-800-562-6188

Private insurance or third-party liability, other than Healthy Options?

Coordination of Benefits Section
1-800-562-6136

Electronic Billing?

(360) 725-1267 or write to:
Electronic Billing
PO Box 45564
Olympia, WA 98504-5564

Where can I find MAA's billing instructions and numbered memoranda?

Go to MAA's website:
http://maa.dshs.wa.gov/RBRVS/rbrvs.htm

Definitions

This section contains definitions, abbreviations, and acronyms used in these billing instructions which relate to the Medical Assistance Program.

Client - An individual who has been determined eligible to receive medical or health care services under any MAA program. [WAC 388-500-0005]

Core Provider Agreement - The basic contract between MAA and an entity providing services to eligible clients. The core provider agreement outlines and defines terms of participation in medical assistance programs. [WAC 388-500-0005]

Department - The state Department of Social and Health Services (DSHS). [WAC 388-550-0005]

Encounter – A face-to-face contact between a health care professional and an Indian Health Service (IHS) beneficiary eligible for Medicaid, for the provision of Title XIX defined services through an IHS or Tribal 638 facility within a 24-hour period ending at midnight, as documented in the patient's record.

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report. [WAC 388-500-0005]

Healthy Options program or HO program - The Medical Assistance Administration's (MAA) prepaid managed care health program for Medicaid-eligible clients and CHIP clients. [WAC 388-500-0005]

Indian Health Service (IHS) - A federal agency under the Department of Health and Human Services and contracted tribal health programs entrusted with the responsibility to assist eligible American Indians and Alaska Natives with health care services.

Internal Control Number (ICN) – A 17-digit claim number appearing on the MAA Remittance and Status Report near the client's name that is used as a means of identifying the claim.

Managed care - A comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services. These services are provided either through a managed care organization (MCO) or primary care case management (PCCM) provider. [WAC 388-500-0005]

Maximum allowable - The maximum dollar amount MAA will reimburse a provider for a specific service, supply, or piece of equipment. [WAC 388-500-0005]

Medicaid - the state and federally funded Title XIX program under which medical care is provided to persons eligible for the:

(1) Categorically needy program; or
(2) Medically needy program.
[WAC 388-500-0005]

Medical Assistance Administration (MAA) - The administration within DSHS authorized by the secretary to administer the acute care portion of Title XIX Medicaid, Title XXI state-children's health insurance program (S-CHIP), Title XVI, and the state-funded medical care programs, with the exception of certain nonmedical services for persons with chronic disabilities.
[WAC 388-500-0005]

Medical identification card - The document MAA uses to identify a client's eligibility for a medical program. These cards were formerly known as medical assistance identification (MAID) cards.
[WAC 388-500-0005]

Medically necessary - A term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all. [WAC 388-500-0005]

Medicare - The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

(1) **"Part A"** covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.

(2) **"Part B"** is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare.
[WAC 388-500-0005]

Patient Identification Code (PIC) - An alphanumeric code that is assigned to each Medical Assistance client and which consists of:

a) First and middle initials (or a dash (-) if the middle initial is not available).
b) Six-digit birthdate, consisting of numerals only (MMDDYY).
c) First five letters of the last name (and spaces if the name is fewer than five letters).
d) Alpha or numeric character (tiebreaker).

Primary care case management (PCCM) - A system under which a provider contracts with the state to furnish case management services, which include the provision, coordination and monitoring of primary care to Medicaid clients. [WAC 388-500-0005]

Provider - Any person or organization that has a signed contract or core provider agreement with DSHS to provide services to eligible clients. [WAC 388-500-0005]

Remittance and Status Report (RA) - A report produced by the Medicaid Management Information System (MMIS) [MAA's claims processing system] that provides detailed information concerning submitted claims and other financial transactions.

Revised Code of Washington (RCW) - Washington State laws.

Third Party - Any entity that is or may be liable to pay all or part of the medical cost of care of a federal Medicaid or state medical care client. [WAC 388-500-0005]

Title XIX - The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid.
[WAC 388-500-0005]

Tribal 638 Facility – A facility operated by a tribe or a tribal organization, and funded by Title I or III of the Indian Self Determination and Education Assistance Act (Public Law 93-638). A tribal 638 facility is paid at the rates negotiated between the Center for Medicare & Medicaid Services and the IHS. These rates are published in the Federal Register or Federal Register Notices.

Tribal Mental Health Services – A qualified tribal mental health program which contracts with the Department of Social and Health Services under the provisions of the December 1996 Memorandum of Agreement between the federal Health Care Financing Administration and Indian Health Services.

Usual and customary charge - The fee that the provider typically charges the general public for the product or service.
[WAC 388-500-0005]

Washington Administrative Code (WAC) - Codified rules of the State of Washington.

"638" Contract – A contract between tribes and the Indian Health Service that states tribes will assume responsibility for providing health care for all their members. Authorized by Public Law 93-638, the Indian Self Determination Act, as amended, U.S. Code, § 450 et seq.

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Indian Health Services

About the program

It is the goal of the Medical Assistance Administration (MAA), in cooperation with the Indian Health Service, to raise the health status of American Indians to the highest possible level.

Enrollment Options

If a client is an American Indian/Alaska Native (AI/AN) who meets the provisions of 25 U.S.C. 1603(c)(d) for federally recognized tribal members and their descendants, the client may choose one of the following per WAC 388-538-130:

- Enrollment with a managed care organization (MCO) available in their area;
- Enrollment with an Indian or tribal primary care case management (PCCM) provider available in their area; or
- MAA's fee-for-service system.

If the client is enrolled in a managed care plan and choose to enroll with an Indian or tribal PCCM, the client must request an exemption/disenrollment from managed care through the Exception Case Management Section in MAA at 1-800-794-4360.

Who is eligible to obtain services from IHS?

American Indian/Alaska Native clients with one of the following medical identifiers on their DSHS Medical Identification cards **are eligible** to receive services from Indian Health Service or Tribal 638 facilities:

Medical Program Identifier	Medical Program Name
CNP	Categorically Needy Program
CNP-CHIP	CNP-Children's Health Insurance Program
CNP-QMB	CNP-Qualified Medicare Beneficiary
LCP-MNP	Limited Casualty Program – Medically Needy Program
MNP-QMB	Medically Needy Program – Qualified Medicare Beneficiary

Note: If the client Medical ID Card does not list one of the above medical program identifiers, please refer the client to his/her local Community Services Office (CSO) to be evaluated for a possible change in their Medical Assistance program that would enable them to receive services from Indian Health Service or Tribal 638 facilities.

Who is not eligible to obtain services from IHS?

American Indian/Alaska Native clients with one of the following identifiers on their DSHS Medical ID cards **are not eligible** to receive services from Indian Health Service or Tribal 638 facilities:

Medical Program Identifier	Medical Program Name
Family Planning Only	Family Planning Only
GAU-No out of state care	General Assistance Unemployable
QMB – Medicare Only	Qualified Medicare Beneficiary
W – No out of state care	

Provider Requirements

To become a provider with MAA, you must first be an Indian Health Service (IHS) or a Tribal 638 facility.

To find out what the specific requirements are to become an IHS or Tribal 638 facility, contact the:

Indian Health Services
Portland Area Office
503-326-2023, 503-326-7277,
503-326-3288, or 503-326-7273

☞ **Note**: A tribal 638 facility may elect to participate as a Federally Qualified Health Center (FQHC) rather than becoming an Indian Health provider. As an FQHC, you would be subject to FQHC billing requirements. For information call: (360) 586-3745.

What is covered?

- MAA will cover **one medical encounter per client, per day**.

  Exception: If, due to an emergency, the same client returns on the same day for a second visit with a different diagnosis, a second encounter is allowed.

  Example: *If a client comes in for diabetes and hypertension, it is considered one medical encounter, regardless of how many providers the client sees in the course of the visit. However, if the client leaves, slips on the ice and returns for emergency care, that is a second diagnostic episode and a second encounter may be billed. As always, documentation must be present for all encounters.*

- MAA will cover **one dental encounter per client, per day** (regardless of how many procedures are done or how many providers are seen).

  Exception: If, due to an emergency, the same client returns on the same day for a second visit and has a different diagnosis, a second encounter is allowed.

  Example: *If a client comes in for a routine cleaning and x-rays, it is considered one dental encounter, regardless of how many providers the client sees in the course of the visit. However, if the client leaves, chips a tooth, and returns for emergency care, that is a second diagnostic episode and a second encounter may be billed. As always, documentation must be present for all encounters.*

How do I bill?

- Complete a HCFA-1500 claim form. (See *How to Complete the HCFA-1500 Claim Form* and attached samples.)

- Use HCPCS code T1015 **Clinic visit/encounter, all-inclusive** in field 24D on the HCFA-1500 claim form (see example).

Tribal Mental Health Services

About the program

In Washington State, Medicaid eligible individuals generally receive mental health services through providers that contract with Regional Support Networks.

Through a Memorandum of Agreement (MOA) between the Indian Health Service and the federal Health Care Financing Administration, Medicaid-eligible American Indians/Alaska Natives may elect to receive mental health services through Tribal Mental Health programs.

Who is eligible to receive Tribal Mental Health Services?

Clients with one of the following identifiers on their DSHS Medical Identification Cards **are eligible** to receive mental health services from Tribal Mental Health programs:

Medical Program Identifier	Medical Program Name
CNP	Categorically Needy Program
CNP-CHIP	CNP-Children's Health Insurance Program
CNP-QMB	CNP-Qualified Medicare Beneficiary
LCP-MNP	Limited Casualty Program – Medically Needy Program
MNP-QMB	Medically Needy Program – Qualified Medicare Beneficiary

Note: If the client Medical ID Card does not list one of the above medical program identifiers, please refer the client to his/her local Community Services Office (CSO) to be evaluated for a possible change in their Medical Assistance program that would enable them to receive Tribal Mental Health Services.

Who is not eligible to receive Tribal Mental Health Services?

Clients with one of the following identifiers on their DSHS Medical ID Cards **are not eligible** to receive mental health services from Tribal Mental Health programs:

Medical Program Identifier	Medical Program Name
Family Planning Only	Family Planning Only
GAU-No out of state care	General Assistance Unemployable
QMB – Medicare Only	Qualified Medicare Beneficiary
W – No out of state care	

Provider Requirements

To become a provider with MAA and the Mental Health Division, you must:

- Meet the requirements of the December 1996 Memorandum of Agreement between the Health Care Financing Administration (HCFA) and Indian Health Services (IHS); and
- Have a contract with the Mental Health Division.

Providers may do so by exercising one of the following options:

- Be licensed by the Mental Health Division;
- Maintain a "638" contract with Indian Health Services for mental health services;
- Maintain a contract with DSHS that specifies the Tribal Mental Health certification standards will be met; or
- Maintain private accreditation standards of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the Commission on Accreditation of Rehabilitation Facilities (CARF).

Tribes must submit information to the Mental Health Division when they begin their contract and when there are changes in enrollment status of those they serve. Contact the Mental Health Division.

What is covered?

- MAA will cover one mental health professional encounter per client, per day.

  Exception: If, due to an emergency, the same client returns on the same day for a second visit and has a different diagnosis, a second encounter is allowed.

  Example: *If a client comes in for psychotropic medication management, it is considered one mental health professional encounter, regardless of how many providers the client sees in the course of the visit. However, if the client leaves, becomes suicidal and returns for emergency care, that is a second diagnostic episode and a second mental health professional encounter may be billed. As always, documentation must be present for all encounters.*

How do I bill?

- Complete a HCFA-1500 claim form. (See *How to Complete the HCFA-1500 Claim Form* and attached samples.)

- Use **HCPCS code T1015** with **modifier HE** to indicate Tribal Mental Health Encounter in field 24D on the HCFA-1500 claim form. This encounter code is specifically for mental health services.

- Tribes should refer to the ICD-9-CM Manual for diagnostic codes, usually the 300 series, having to do with mental illness.

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Billing

What is the time limit for billing? [Refer to WAC 388-502-0150]

MAA requires providers to submit an initial claim, be assigned an internal control number (ICN), and adjust all claims in a timely manner. MAA has two timeliness standards for: 1) initial claims; and 2) resubmitted claims.

- **Initial Claims**

  - ✓ MAA requires providers to obtain an ICN for an **initial claim** within 365 days from any of the following:

    - The date the provider furnishes the service to the eligible client;
    - The date a final fair hearing decision is entered that impacts the particular claim;
    - The date a court orders MAA to cover the services; or
    - The date DSHS certifies a client eligible under delayed[1] certification criteria.

  - ✓ MAA may grant exceptions to the 365 day time limit for **initial claims** when billing delays are caused by either of the following:

    - DSHS certification of a client for a retroactive[2] period; or
    - The provider proves to MAA's satisfaction that there are extenuating circumstances.

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[1] **Delayed Certification -** According to WAC 388-500-0005, delayed certification means department approval of a person's eligibility for a covered service made after the established application processing time limits. If, due to delayed certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

Eligibility Established After Date of Service but Within the Same Month - If the client becomes eligible for a covered service that has already been provided because the client applied to the department for medical services later in the same month the service was provided (and is made eligible from the first day of the month), **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

[2] **Retroactive Certification -** According to WAC 388-500-0005, retroactive period means the three calendar months before the month of application (month in which client applied). If, due to retroactive certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for any unpaid charges for the service; **and may refund** any payment already received from the client or anyone acting on the client's behalf, and after refunding the payment, the provider may bill MAA for the service.

- **Resubmitted Claims**

  Providers may **resubmit, modify, or adjust** any timely initial claim, except prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.

  ☞ **Note:** MAA does not accept any claim for resubmission, modification, or adjustment after the time period listed above.

- The time periods do not apply to overpayments that the provider must refund to DSHS. After the allotted time periods, a provider may not refund overpayments to MAA by claim adjustment. The provider must refund overpayments to MAA by a negotiable financial instrument such as a bank check.

- The provider, or any agent of the provider, must not bill a client or a client's estate when:

✓ The provider fails to meet these listed requirements; and
✓ MAA does not pay the claim.

Fees

Bill MAA your usual and customary fee (what you charge the general public).
MAA's payment will be the lower of the billed charges, or MAA's maximum allowable rate, and is payment in full.

Third-Party Liability

Although the billing time limit for MAA is 365 days, an insurance carrier's time limit for claim submissions may be different. It is your responsibility to meet the insurance carrier's requirements relating to billing time limits, as well as MAA's, prior to any payment by MAA.

You must bill the insurance carrier(s) indicated on the client's Medical Identification Card. Even if you haven't received notification of action by the insurance carrier, MAA's 365-day billing time limit must be met. If your claim is denied due to any existing third-party liability, refer to the corresponding MAA Remittance and Status Report for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by MAA, or if you have reason to believe that MAA may make an additional payment:

- Submit a completed claim form to MAA.
- Attach the insurance carrier's statement.
- If rebilling, also attach a copy of the MAA Remittance and Status Report showing the previous denial; or
- If you are rebilling electronically, list the claim number (ICN) of the previous denial in the *Comments* field of the Electronic Media Claim (EMC).

The list of third-party carrier codes is in the General Information Booklet, or you may call the Coordination of Benefits Section at 1-800-562-6136 if you have further questions.

What records must be kept? [Refer to WAC 388-502-0020]

Enrolled providers must:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:

  - ✓ Patient's name and date of birth;
  - ✓ Dates of service(s);
  - ✓ Name and title of person performing the service, if other than the billing practitioner;
  - ✓ Chief complaint or reason for each visit;
  - ✓ Pertinent medical history;
  - ✓ Pertinent findings on examination;
  - ✓ Medications, equipment, and/or supplies prescribed or provided;
  - ✓ Description of treatment (when applicable);
  - ✓ Recommendations for additional treatments, procedures, or consultations;
  - ✓ X-rays, tests, and results;
  - ✓ Plan of treatment and/or care, and outcome; and
  - ✓ Specific claims and payments received for services.

- Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains.

- Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services, upon their request, for at least six years from the date of service or more if required by federal or state law or regulation.

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**A provider may contact MAA with questions regarding MAA's programs. However, MAA's response is based solely on the information provided to MAA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern MAA's programs.
(Refer to WAC 388-502-0020[2])**

How to Complete the HCFA-1500 Claim Form

The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing the Medical Assistance Administration (MAA). Some field titles may not reflect their usage for this claim type. The numbered boxes on the claim form are referred to as fields.

Important!

Guidelines/Instructions:

- **Use only the original preprinted red and white HCFA-1500 claim forms** (version 12/90 or later, preferably on 20# paper). This form is designed specifically for optical character recognition (OCR) systems. The scanner cannot read black and white (copied, carbon, or laser-printer generated) HCFA-1500 claim forms.

- **Do not use red ink pens, highlighters, "post-it notes," stickers, correction fluid or tape** anywhere on the claim form or backup documentation. The red ink and/or highlighter will not be picked up in the scanning process. Vital data will not be recognized. Do not write or use stamps or stickers that say, "REBILL," "TRACER," or "SECOND SUBMISSION" on claim form.

- **Use standard typewritten fonts** that are 10 c.p.i (characters per inch).
  Do not mix character fonts on the same claim form. Do not use italics or script.

- **Use upper case** (capital letters) for all alpha characters.

- **Use black** printer ribbon, ink-jet, or laser printer cartridges. **Make sure ink is not faded or too light!**

- **Ensure all the claim information is entirely contained within the proper field** on the claim form and on the same horizontal plane. Misaligned data will delay processing and may even be missed.

- **Place only six detail lines on each claim form**. MAA does not accept "continued" claim forms. If more than six detail lines are needed, use additional claim forms.

- **Show the total amount for each claim form separately**. Do not indicate the entire total (for all claims) on the last claim form; **total each claim form**.

Field Description/Instructions

1A. **Insured's ID No.**: Required. Enter the Patient Identification Code (PIC) - an alphanumeric code assigned to each Medical Assistance client - exactly as shown on the client's DSHS Medical ID Card. This number consists of the client's:

- First and middle initials (a dash [-] *must* be used if the middle initial is not available).
- Six-digit birthdate, consisting of *numerals only* (MMDDYY).
- First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker.
- An alpha or numeric character (tiebreaker).

For example:

- Mary C. Johnson's PIC looks like this: MC010667JOHNSB.
- John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100257LEE B.
- Tom O'Malley's PIC should look like this: TC020652O'MALA (**Note:** Always use the exact PIC as it appears on the client's Medical ID Card regardless of whether it follows the above examples.)

Field Description/Instructions

2. **Patient's Name**: Required. Enter the last name, first name, and middle initial of the Medicaid client (the receiver of the services for which you are billing).

3. **Patient's Birthdate**: Required. Enter the birthdate of the Medicaid client.

17. **Name of Referring Physician or Other Source**: When applicable, enter the referring physician or Primary Care Case Manager name. This field must be completed for consultations, or for referred laboratory or radiology services (or any other services indicated in your billing instructions as requiring a referral source).

17a. **I.D. Number of Referring Physician**: When applicable, enter the seven-digit, MAA-assigned identification number of the provider who referred or ordered the medical service; OR 2) when the Primary Care Case Manager (PCCM) referred the service, enter his/her seven-digit identification number here. If the client is enrolled in a PCCM plan and the PCCM referral number is not in this field when you bill MAA, the claim will be denied.

19. **Reserved for Local Use**: When applicable, enter indicator **B** to indicate *Baby on Parent's PIC*. If the client is one of twins or triplets, enter the **B** and indicate the client on the claim as "twin A or B" or triplet "A, B, or C" as appropriate.

21. **Diagnosis or Nature of Illness or Injury**: When applicable, enter the appropriate diagnosis code(s) in areas 1, 2, 3, and 4.

22. **Medicaid Resubmission**: When applicable. If this billing is being submitted beyond the 365-day billing time limit, enter the ICN that verifies that your claim was originally submitted within the time limit. (The ICN number is the claim number listed on the Remittance and Status Report.)

24. **Enter only one (1) procedure code per detail line (fields 24A - 24K).**

24A. **Date(s) of Service**: Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., October 04, 2003 = 100403).

24B. **Place of Service**: Required. Use the following code for Washington State Medicaid:

Code Number	To Be Used For

05 IHS Free-Standing Facility

A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians or Alaska Natives who do not require hospitalization.

06 IHS Provider-Based Facility

A facility or location, owned and operated by the Indian Health Services, which provide diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients.

07 Tribal 638 Free-Standing Facility

A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members who do not require hospitalization.

08 Tribal 638 Provider Based Facility

A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members admitted as inpatients or outpatients.

24D. **Procedures, Services or Supplies CPT/HCPCS**: Required. Enter the appropriate procedure code as follows:

T1015	Indian Health Srvcs
T1015 HE	Tribal Mental Health Services

24E. **Diagnosis Code**: Required. Enter the ICD-9-CM diagnosis code related to the procedure or service being billed (for each item listed in 24D). A diagnosis code is required for each service or line billed. Enter the code exactly as shown in ICD-9-CM.

24F. **$ Charges**: Required. Enter your usual and customary charge for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed Do not include dollar signs or decimals in this field.

24G. **Days or Units**: Required. Enter the total number of days or units (up to 999) for each line. These figures must be whole units.

25. **Federal Tax I.D. Number: Leave this field blank.**

26. **Your Patient's Account No.**: Not required. Enter an alphanumeric ID number, i.e., a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading *Patient Account Number*.

28. **Total Charge**: Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. **Amount Paid**: If you receive an insurance payment or client-paid amount, show the amount here, and attach a copy of the insurance Explanation of Benefits (EOB). If payment is received from source(s) other than insurance, specify the source in *field 10d*. Do not use dollar signs or decimals in this field or put Medicare payment here.

30. **Balance Due**: Required. Enter balance due. Enter total charges minus any amount(s) in *field 29*. Do not use dollar signs or decimals in this field.

33. **Physician's, Supplier's Billing Name, Address, Zip Code and Phone #**: Required. Put the Name, Address, and Phone # on all claim forms.

PIN#: Please enter your seven-digit provider number assigned to you by MAA.

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

SAMPLE

INDIAN HEALTH SERVICES

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE ☐ (Medicare #) MEDICAID ☒ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): MJ070160SMITHA

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SMITH MARY J

3. PATIENT'S BIRTH DATE MM DD YY: 07 01 60 SEX M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 5555 NEVERENDING ROAD

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY: ANYWHERE STATE: WA

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY: STATE:

ZIP CODE: 98000 TELEPHONE (Include Area Code): ( )

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 848.9
2.
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 11 01 03	11 01 03	11		T1015		848.9	15200	1				
2												
3												
4												
5												
6												

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. $ TOTAL CHARGE: 15200

29. $ AMOUNT PAID:

30. $ BALANCE DUE: 15200

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

UPPER COUNTY CLINIC
PO BOX 333
ANYTOWN WA 98500 (360) 242-0000

PIN# 7099999 GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

SAMPLE

TRIBAL MENTAL HEALTH

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) | MEDICAID [X] (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): MJ070160SMITHA

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SMITH MARY J

3. PATIENT'S BIRTH DATE: MM 07 DD 01 YY 60 SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 5555 NEVERENDING ROAD

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: ANYWHERE | STATE: WA

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]

CITY | STATE

ZIP CODE: 98000 | TELEPHONE (Include Area Code): ( )

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE | TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY SEX: M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX: M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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SIGNED _____ DATE _____

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16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 316.__
2. _____.__
3. _____.__
4. _____.__

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 11 01 03	11 01 03	11		T1015	HE	316	15200	1				
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. $ TOTAL CHARGE: 15200

29. $ AMOUNT PAID:

30. $ BALANCE DUE: 15200

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

LOWER COUNTY CLINIC
PO BOX 333
ANYTOWN WA 98500 (360) 242-0000

PIN# 1989999 GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500